MLS National Medical Evaluation Services, Inc.

A MLS Group Company

May 16, 2006

Re: Moira C. Goletz
Claim Number: 10371073

INDEPENDENT PEER REVIEW

To Whom It May Concern:

LIST OF MEDICAL DOCUMENTATION

- Brief claim summary and analysis of medical records beginning 03/20/2001.
- Records from Patrick M. Voy, M.D. which appears to be a review and analysis dated 12/30/2003 with a repeat medical review on 02/10/2004.
- Letter from the patient dated 07/29/2002.
- Letters from John S. Gray to Ms. Christine Latour, manager of Disability Management Services of Prudential Insurance Company.
- Records from Dr. Rowe from 1993 to present.
- Records from John F. Glenn, M.D. from 02/2000 to present.
- Records from Eric R. Tamesis, M.D. from 02/2001 to present.
- Reports of clinical laboratory studies from 2002.
- An independent medical evaluation from Peter B. Bandera, M.D. dated 10/30/2002.
- Reports from Arrow Ger, M.D. from 2003.
- An operative report from Arrow Ger, M.D. dated 02/12/2003.
- Interpretive reports of imaging studies including a three-page bone scan dated 03/23/2001.
- Physical therapy reports from Brown and Associates Orthopedic Sports Therapy.
- Reports from Bay Health Medical Center, Rehabilitation Center, and Kent General Hospital.
- Interpretive report of a MRI of the left wrist dated 12/17/2002.
- Additional clinical laboratory results.

SUMMARY OF MEDICAL DOCUMENTATION

Moira Goletz is a 48 -year-old Cardmember Advocacy Specialist who went out of work on May 1, 2000, when being diagnosed with inflammatory arthritis, back spasms, and knee pain.

There is a consultation on patient Moira Goletz from rheumatologist Dr. Eric Tamesis in which he notes that she is 42 years old at the time with multiple joint pain particularly involving the left elbow with a burning sensation going down the fingers and hands. Also noted are episodes of a cracking sensation of her left wrist followed by persistent pain that has been present for the past six months. Physical therapy has not provided much benefit. She reported two injections of corticosteroid into the left wrist without any relief. Also noted are complaints of neck pain, paraesthesia, weakness and stiffness of both hands, use of Vioxx and other medications has not provided much relief.

Past medical history includes ulcer disease, gallbladder surgery, and bilateral carpal tunnel surgery. It is noted that she previously worked in a computer firm. It is noted that she has had no pregnancies but has two children. Family history identifies arthritis, osteoarthritis, diabetes mellitus, hypertension, and gout. Review of systems describes a 30-pound weight loss over the past several months while on a diet. It is noted that she does complain of Raynaud's but additional details are not offered. The physical examination describes tenderness to palpation on the lateral and medial condyle on the right elbow increased with forearm pronation and supination. Also evidence of tenderness to palpation of the MCP and PIP of the left hand and PIP of the right hand. There is no evidence of synovitis or effusion. Mention is made of bilateral positive Tinel and Phalen signs and crepitus of both knees without effusion or synovitis. Pain on abduction of the left shoulder to approximately 60 degrees with tenderness to palpation on glenohumeral joint and subacromial bursa. Dr. Temesis' assessment included poly arthritis, bilateral carpal tunnel syndrome, and lateral and medial epicondylitis of the left elbow. He undertook a diagnostic evaluation.

In an office note dated 03/09/2001 indicates that the patient complains of stiffness of both of her hands as well as generalized stiffness involving her neck, both shoulders and hips and that she is not improving. Physical examination describes a new finding. Specifically, Dr. Temesis reports the examination of small joints of her hands now reveal evidence of synovitis and tenderness to palpation of the MCP and PIP of both hands. He reports marked tenderness of palpation of her left wrist. It is noted that his report of evidence of synovitis does not provide any specific detail such as the finding of synovial thickening that led him to interpret his exam findings as representing synovitis.

Also, he makes no mention of swelling, particularly soft-tissue swelling. He notes her laboratory studies indicating negative rheumatoid factor, sed rate, C-reactive protein. His assessment included arthritis with associated synovitis of the small joints of the hands. He reports that despite her negative serologies and inflammatory markers, she does have the appearance of an inflammatory arthritis.

A note dated 03/29/2001 identifies her complaint of low back pain and stiffness have improve although she continues to complain of diffuse achiness mostly involving her neck and throbbing sensation of her wrist and numbness in the fourth and fifth digits of her fingers. She apparently was having difficulty with sleep reporting that it has improved. Medications appeared to include Elavil, prednisone 5 mg twice daily. His examination of the musculoskeletal system indicates, "still reveals no definite synovitis or effusion of the wrists, however she still has tenderness to palpation of the left carpal bone." I find this comment somewhat inconsistent with his previous note of 03/21/2001 in which he notes that "she now reveals evidence of synovitis."

A note dated 02/04/2002 mentions the possibility of fibromyalgia and that on her last visit, he found no evidence of inflammatory arthritis. She did have poor sleep and he started her on Elavil. It is noted that she is also taking Celebrex 100 mg twice daily. His examination on 02/04/2002 identifies no evidence of synovitis or effusion. He offers his assessment of poly arthritis as well as features of fibromyalgia syndrome.

A noted dated 03/04/2002 identifies exam evidence of tenderness to palpation of the second to fifth PIP and third MCP with some "soft-tissue swelling." He does not mention any synovial changes. Laboratory results are reported and are generally unremarkable with normal rheumatoid factor, normal sedimentation rate, and slightly elevated CRT at 6.1. His assessment continues to include an inflammatory poly arthritis.

His note of 04/04/2002 indicates that he challenged her with prednisone 5 mg twice daily and she had marked improvement. His exam provided no evidence of soft-tissue swelling of various PIP. He did note slightly increased warmth of the left knee but did not describe any swelling of effusion. His assessment included inflammatory arthritis, likely negative seronegative rheumatoid arthritis. He decided to re-challenge her with prednisone 5 mg twice daily and started her on Azulfidine in gradually increasing doses.

His note from 05/08/2002 indicates that the Azulfidine was discontinued after she developed hives. His exam reports evidence of diffuse soft-tissue swelling of various small joints of the hands, but again, there is no mention of synovial change. He reports laboratory studies from 04/09/2002 indicating normal sedimentation and a slight

elevation of CRT of 6.6. CBC and chemistry panel were reported negative. He indicates that he is beginning treatment with methotrexate 7.5 mg weekly along with folic acid and a re-challenge of prednisone 5 mg twice daily.

The record contains a letter from Dr. Temesis regarding Moira Goletz dated 07/11/2002 in which he certifies that he has been managing her care since 02/03/2001 and has found that she has evidence of an inflammatory poly arthritis that significantly limits her ability to do any of her significant activities of daily living.

A note of 06/25/2002 describes an examination finding of no definite synovitis. His assessment of poly arthritis remains.

His note of 07/26/2002 indicates that the MRI revealed evidence of small joint effusion but no tears. It is unclear which joint is the focus of this study. Examination identifies not increased warmth or erythema. No synovial changes or soft-tissue swelling are described. He reports C-reactive protein to be normal. Hepatitis profile was normal. Sedimentation was elevated at 25. His assessment was seronegative rheumatoid arthritis.

A note dated 09/09/2002 indicates a weight of 202 pounds although her height is not given. He reports normal liver function studies, normal sedimentation rate, and a mild elevation of C-reactive protein at 5.9. He mentions his intentions to proceed with a biologic agent such as Remicade.

A noted dated 10/18/2002 is reviewed. The physical examination does not mention any synovial change of joints. The assessment included degenerative joint disease and seronegative inflammatory arthritis. He recommended continuation of treatment with methotrexate 10 mg per week and prednisone 5 mg daily. He notes that he will schedule Remicade infusions one week after her eye exam.

A letter from Dr. Temesis dated 01/08/2003 again notes a severe disabling arthritis resulting in multiple joint swelling and destruction of joints markedly limiting her activities of daily living. He also notes that he has started Remicade infusion treatment.

A note that was originally dated 10/18/2002 but appears to be changed to 10/18/2003 identifies the joint exam without report of synovial changes or soft-tissue swelling. Note is made of an order of MRI of the back to check for herniation.

A note dated 04/11/2003 indicates continued treatment of Methotrexate 10 mg weekly with Remicade 4 mg by infusion every eight weeks. The joint exam fails to identify any synovial changes or soft-tissue swelling. Marked tenderness however is described.

A letter by Dr. Temesis dated 05/08/2003 indicates that any inflammatory arthritis can produce generalized joint pain and stiffness. It can involve any joint even in the absence of definite swelling such as pain to the shoulders and hips. He notes that the patient was started on Remicade followed by improvement of joint swelling. He also notes that prior to the use of these immunosuppressant agents, there was significant joint synovitis and soft-tissue swelling of the hands which have improved with therapy.

A note dated 05/16/2003 again provides a joint exam without identifying any synovial change or soft-tissue swelling.

A note of 06/26/2003 provides a joint exam without any description of synovial thickening or soft-tissue swelling. Again significant tenderness is noted over multiple joints. Laboratory studies reported include a sedimentation rate of 42, and C-reactive protein of 7, both significantly elevated. A chemistry panel is reported normal. Rheumatoid factor is reported at 6.5, essentially normal.

A report dated 07/30/2003 again provides a joint exam describing tenderness without identifying any soft-tissue swelling, synovial thickening, or effusions. Sedimentation rate is reported at 35, while CRT and chemistry panel are normal.

A letter from Dr. Temesis to John S. Grady dated 08/27/2003 notes that prior to the use of immunosuppressant agents, there was significant joint synovitis of her hands which have showed some improvement with therapy. He notes that Ms. Goletz's labs correlate with an ongoing inflammatory disease activity that can occur despite no significant swelling. He notes that her correct diagnosis is seronegative rheumatoid arthritis. He also notes that her subjective symptoms correlate with her objective findings.

An interpretive report of a three-page bone scan of the upper extremities dated 03/23/2001 indicates a normal study.

An interpretive report of a MRI examination of the lumbar spine identifies mild facet arthropathy but otherwise normal study.

A report of x-rays of the lumbar spine indicates very minimal early spondylosis and popliteal left arthritis, otherwise normal with well-preserved vertebral bodies and alignment, disc spaces, and neural foraminal.

An independent medical evaluation performed by Peter Bandera, M.D. on 10/30/2002 is reviewed. His examination identifies "trace swelling of the hands bilaterally" but does not identify any synovial change or swelling localizing to joints. He reports that she does not have reproducible tenderness of the hands or the joints except for the left extensor wrist. He reports that range-of-motion of the shoulder, wrist, and fingers are within normal limits. His impression included seronegative inflammatory poly arthritis by history, multiple nerve transpositions, bilateral elbow and bilateral carpal tunnel release bilaterally, left wrist extensor tendinitis/synovitis with mild degenerative changes by history, left wrist degenerative joint disease versus possible CFCC tear, and cervical/thoracic/lumbosacral sprain strain by history.

The record contains reports from Arrow Ger, M.D. Dr. Ger undertook an operative procedure described as exploration of the dorsum of the left wrist with excision of ganglion cyst. This was performed on 02/12/2003. Dr. Ger's operative findings are reported. He indicates that there is a ganglion cyst arising from the wrist. The capsule of the dorsum of the wrist is deficient. This ganglion is excised and sent for histology. The undersurface of the fourth compartment is explored and no terminal branch of the posterior interosseus nerve is seen. This has probably been removed previously. The carpal bones in this area are visualized and appear normal. Nowhere in his operative report does he describe any synovial changes or inflammatory nodules.

A note dated 01/07/2003 is reviewed. He notes that the patient has had ganglion surgery at the dorsum of the left wrist and he is awaiting the MRI report but the proximal carpal row certainly appears normal.

An imaging report from Johns Hopkins dated 06/14/2002 identifies no evidence of meniscal tear but also identifies the presence of a very small joint effusion. It indicates normal bone marrow and no focal cartilage defects.

MRI examination of the left wrist was undertaken 12/17/2002. The report identifies a dorsal pericapsular ganglion cyst centered at the level of the proximal capitate. Enlargement of the median nerve at the carpal tunnel level but no definite evidence of a TFC rupture. The report does not identify any evidence of bone edema, erosive or cystic change, or evidence of synovitis, or joint effusion.

An x-ray of the chest interpretive report dated 04/18/2003 was compared to a study of 01/28/2001 and identified no rheumatoid lung nodules, interstitial fibrosis, or lymphadenopathy. In short, the study was felt to be normal.

CONCLUSION

1. Based on the documentation reviewed, does Ms. Goletz have functional impairment(s) relating to a rheumatological condition from October 30, 2002 forward? If so, please list the functional impairment(s) and the evidence supporting your opinion.

Based on the documentation reviewed, Ms. Goletz does not have functional impairments relating to inflammatory arthritis or a defined rheumatologic condition from 10/30/2002 forward. Please refer to question #5 for further explanation.

2. Please identify appropriate restrictions and/or limitations in terms of Ms. Goletz' ability to sit, stand, walk, reach, lift, carry, and perform repetitive upper extremity activities, etc., based on the functional impairment(s) you have noted above. Please also note the duration of any applicable restrictions and/or limitations and the evidence supporting your opinion if not elsewhere documented.

I do not identify any rheumatological basis within the accompanying medical record, to support restrictions and/or limitations based upon an underlying inflammatory condition or rheumatological condition.

3. If medical records are indicating significant impairment, please comment on expected treatment, duration and prognosis.

As described above, the findings do not indicate significant impairment relating solely to an underlying rheumatologic condition/inflammatory arthritis.

4. Do the medical records support significant adverse side effects from any medication or combination of medications? If so, please specify which medication(s) and for what time period, providing evidence of your opinion.

The medical records identify the development of hives following treatment with sulfasalazine, but otherwise, there is no further evidence identified in the accompanying record to indicate adverse side effects including cognitive deficit from any other medication or combination of medications.

5. If you opine that Ms. Goletz is not functionally impaired, please provide a detailed explanation supporting your opinion.

I do opine that Ms. Goletz is not functionally impaired due to an underlying rheumatologic condition/inflammatory arthritis based upon my review of the accompanying medical record.

In reviewing the records from the patient's rheumatologist, Dr. Temesis, there are findings of synovitis on only one occasion, specifically the visit of 03/09/2001 in which he mentions that his examination of small joints to the hands now reveal evidence of synovitis. My view is that synovitis is an interpretation and not a physical finding. However, it is probably fair to interpret his report as indicating synovial thickening. His following note of 03/29/2001 indicates that his exam of the musculoskeletal system still reveals no synovitis or effusions of the hands or wrists. This comment suggests that he has not identified synovitis or effusions in the past and contradicts the statement in the prior note of 02/23/2001. In any case, after reviewing all of the notes from his office that were provided in the accompanying record, there was no further mention of synovitis or synovial thickening in the physical examinations. Indeed, the overwhelming majority of exam findings throughout these notes do not mention soft-tissue swelling or synovial thickening. Furthermore, testing for rheumatoid factor was consistently negative as was ANA. I do not identify any test for anti-CCP, a newer test for rheumatoid arthritis which is less sensitive but somewhat more specific and reported to be present in up to 40 percent of patients with seronegative rheumatoid arthritis. Furthermore, the report of the bone scan of the upper extremities was reported as normal. Although this study was done in an attempt to address the possibility of reflex sympathetic dystrophy, the study would typically indicate increased uptake in small joints in rheumatoid arthritis if that condition were present and active. The fact that the study demonstrated no such abnormality, weighs against the presence of active inflammation of the small joints of the hands as well as other joints of the upper extremities that were included in the study. In addition, Dr. Arrow Ger undertook surgical removal of a ganglion cyst of the left wrist in February of 2003. His operative report describes the operative findings and fails to identify any evidence of inflammation of the wrist or evidence of synovitis. The description is typical of a common ganglion cyst which he surgically removed. Also, a MRI of the left wrist dated 12/17/2002 demonstrated the ganglion cyst but identified no evidence of synovitis or joint effusion, again weighing against the presence of an underlying inflammatory process. The evidence just cited weighs heavily against the presence of an underlying inflammatory arthritis. The notes from Dr. Temesis do not provide a clinical basis for identifying a significant response to immunosuppressive therapy. I did identify findings of a transient increase of sedimentation rate and C-reactive protein on one occasion.

These are non-specific and the fact that they were only elevated on one occasion while being in the normal range for most of the duration of her symptoms suggests that the transient elevation does not represent underlying inflammation in her joints. In conclusion, the record fails to identify a medical basis of an underlying arthritis or any resulting impairments or restrictions due to such an arthritis.

I further declare under penalty of applicable law that I personally performed this evaluation and prepared this report on the date and location specified. Furthermore, I state under penalty of applicable law that I dictated this report to the MLS transcription service and that I have reviewed the transcribed report and that this report is true and correct.

Sincerely,

R. Karr MD

Reynold Karr, M.D.
Diplomate, American Board of Internal Medicine
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